Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) NAME OF PROVIDER OR SUPPLIER: BUCKTAIL MEDICAL CENTER, THE STATE LICENSE NUMBER: 549601			:				EY
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	CORRECTIVE ACTION SHOULD BE COMP.		(X5) COMPLETE DATE	
P 0000	This report is for new of Portable X-ray System 2023. The Bucktail Mowere in full compliance Pennsylvania Departm Regulations for Hospit Subparts A and B, Nov June 1998.	15, d they ents of the s and rt IV,	P 0000				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

State Form P2SI11 IF CONTINUATION SHEET Page 1 of 1



Certified End Page

BUCKTAIL MEDICAL CENTER, THE

STATE LICENSE NUMBER: 549601 SURVEY EXIT DATE: 05/18/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

Jeanne Jaim

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY